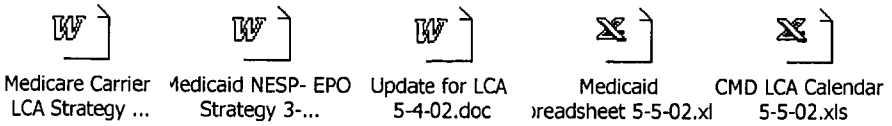
TAB F

From: Reese, Mark [OBI]
Sent: Sunday, May 05, 2002 4:16 PM
To: Pearson, Bill [OBI]
Cc: Pickell, Eileen [OBI]; Dooley, Cathleen [OBI]; Hayes, Rebecca [OBI]; Reese, Mark [OBI]
Subject: Medicare/Medicaid Updates and Strategies



Pivotal Event: NESP has created a profit advantage due to the current AWP pricing of NESP. NESP is currently being marketed as a more profitable alternative to EPO.

Current Environment: The AWP calculation for NESP is (List X 25%) and the AWP calculation for PROCRIT is (List X 20%). This disparity gives the providers that utilize red blood cell growth factors a greater profit if NESP is utilized. In a supportive care market where safety and efficacy are not differentiated for the two products, profitability may be the only difference between the two products. Therefore, the providers will switch to NESP due to the increase in profit.

OBP Strategic Position: PROCRIT's dosing in the oncology market (40,000 units QW) is less expensive than the pricing for NESP given 2.25 mcg/kg QW (quoted from the compendia reference).

Goal: PROCRIT's pricing must be considered the least costly alternative for the two red blood cell growth factors by the Medicare carriers. Both drugs would be a covered benefit, however the AWP – 5% for EPO would be the amount paid for both products.

Suggested Immediate Action Steps:

- Alter the Cost Calculator to reflect line items that would interest a Carrier Medical Director (i.e., remove rebates and discounts, add the AWP multiplier for both drugs, demonstrate the impact to the payor and the patient). – *MR Approval committee on 2-27-02*
- Obtain examples of LCA language in Lupron/Zoladex Medicare guidelines for the Reimbursement team. – *BH from Documedics 2-29-02*
- Determine the number of Medicare patients per carrier to demonstrate the value with the calculator. – *MR working with Business Analytics 2-29-02*
- Create presentation for the reimbursement team to present to the CMDs that includes the following: "To dispel the incorrect message that NESP is cheaper than EPO, and that providers are encouraged to use NESP so they can make more money off of Medicare." - *MR working with TH to create presentation*
- Presentation to include:
  - AWP disparity of 20% vs. 25% for EPO and NESP respectively.
  - The current dosage of EPO and NESP. Utilizing the USPDI dosage for the oncology patient (2.25 mcg/kg QW).
  - Conversion of the Locatelli paper to establish an EPO/NESP comparison.
  - Provide the cost differentiation of Dr. Price's cost comparison.
  - Discuss Dr. Stone's cost comparison and letter detailing his LCA decision.
  - Self-administration in NESP label reason for not C code in January, 2002.
  - Suggest that CMDs invoke the LCA option that they have for red blood cell growth factors.
- Reimbursement Managers and Clinical Affairs Managers make appointments with the CMDs in their respective areas.
- Refresh the Reimbursement managers and the Clinical Affairs managers on

the following subjects as it relates to this strategy:
  - Self-administration language in NESP label is reason for no C code in January 2002.
  - Logic of the disparity in the AWP calculations for NESP and EPO.
  - Clinical review of the Locatelli and USPDI references to demonstrate the NESP dosing.
- Provide training on the calculator and the presentation the week of March 11th.

Resources Needed:
- Clinical Affairs - RCAMs to consider this the first priority to present if the CMD asks any questions concerning off label utilization of NESP or EPO.
- Business Analytics – Data for each carrier and the dollar amount utilized by each carrier in the oncology market.
- Thomas Ferguson – Completion of the cost calculator.

Risk of Strategies:
1. After NESP is in the market, their total cost of therapy is cheaper than PROCRIT. The dose of NESP and the frequency prove to be cheaper that PROCRIT by using less drug, less often than the USPDI references.
2. By saying both drugs are equal, the FI's and carriers will allow NESP to be utilized in all of the same indications that EPO currently enjoys.
3. CMS declares the cost of EPO in the dialysis setting is the LCA price for all utilization of red blood cells.

Pivotal Event: Amgen has launched NESP and Medicaid programs have the authority to implement restrictions on the drugs on their formulary.

Current Environment: PROCRIT is Prior Authorized by some Medicaid programs, and in some programs there are no restrictions.

Our Imperative: We must create an even playing field at worst or a playing field that has a competitive advantage for PROCRIT.

Goal: We need to have every state that is prior authorized for PROCRIT to have a prior authorization for NESP.

Options that the Medicaid programs have:

1. Prior authorize NESP where PROCRIT is prior authorized.
2. Do not prior authorize NESP, do not prior authorize PROCRIT.
3. Prior authorize NESP where PROCRIT is not prior authorized.
4. Prior authorize PROCRIT where NESP is not prior authorized.

OBP Strategic Position: PROCRIT is the proven, safe, efficacious red blood cell growth factor that is less expensive to Medicaid than NESP.

Suggested Immediate Action Steps:

- Create a presentation to address, clinical efficacy as well as utilization of the price calculator to demonstrate the increased cost of NESP to the Medicaid program by April 1st, 2002. – M. Reese, S. Watson, R. Lloyd
- Have the presentation approved by legal and OBP management by April 3rd, 2002. – M. Reese
- Make team calls with the SGA Director, OBP Reimbursement Manager and the Clinical Affairs Pharm D. to the targeted states and PBMs.
- Call on the top 10 Medicaid states that represent 75% of the Medicaid market
  - NY – $40 million
  - CA - $20 million
  - NJ - $15 million
  - PA – 9 million
  - FL – 7.8 million
  - TX – 6.3 million
  - MD – 4.1 million
  - IL – 3.8 million
  - LA – 3.3 million
  - NC – 3.3 million
- Call on the two states that NESP currently has a prior authorization advantage. M. Reese, S. Watson, R. Lloyd
  - IA
  - KY

- Call on the 4 PBMs that are currently targeting Medicaid plans. – M., Reese, S. Watson, R. Lloyd
  - First Health – MI, VT, NH, D.C.
  - Provider Synergies – FL, IL, LA
  - Express Scripts – MD, MS, NM, SC, WV
  - Consultec – NC

Risk of Strategies:

- States that currently do not Prior Authorize PROCRIT may start to PA the drug.
- States could put PROCRIT as a drug that must only be used after NESP fails, due to perceived clinical superiority.

Future Steps:

- Continue to monitor all states activity concerning the PA process to maintain a level playing field for PROCRIT.
- Continue to monitor the PBMs that are venturing into the Medicaid market

STATE	CONTACT PERSON	SGA CONTACT	APPOINTMENT DATE & TIME
FL	Jerry Wells (Pharmacy Director)	Lynn Bahnsen	5/1/2002 14:00
NC	Alan Dodson, MD	George Irving	5/8/02 11:00 AM Concord NC with Alan Dodsaon, MD
KY	Dr. Moore	Ronnie Coleman	May 2, 2002 1:00pm
NY	Mark Butt (Pharmacy Administrator)	Rick Lloyd	May 13, 2002 - 1:00 PM
PA		Jim Cannon	In Progress
LA		Jessica Monroe	In Progress
TX	Leslie Harper	Richard Ponder	Spoke with Leslie via conference call on 4/29
CA		David A. Shestak	June 3,4, or 5, 2000
NJ		Jose Sosa	5/8/2002 1:00
MD		Jimmy Cannon	In Progress

IL	Jerry Johnson		
IA	Sharon A. D'Agostino	28-May-02	

RESULTS

After todays meeting with Alan Dobson,M.D. Director NC medicaid Physician Advisory Group at least (4) things were accomplished.
Procrit* - will probably be removed from PA altogether..
We have been assured that no undue restrictions, or expansion of restrictions will be applied to any of the immunomodulators.
We are assured that under coverage of NC medicaid - that a "level playing field" will exist.
Aranesp/Amgen has not applied for medicaid coverage.
Terry Henderson, Erik Muser, Ronnie Coleman and Karen Lentz met with Dr. Moore. Current Status - Procrit is on PA (Prior Authorization). NESP is NOT due to current legislation that designates that all new products have a 12 month grace period of no PA status. A review of this drug category is forthcoming by the P&T committee (May 23 possibly??). MedImpact (PBM) is doing a review and KY P&T can tweak if desired. We presented Clinical and Economic (Cost Calculator) info to Dr. Moore. He asked lots of questions and found presentation very informative. His policy was to not distribute the cost info to P&T members, but stated that we could educate them if we desired. He clarified issue that both Procrit and NESP were covered, but there was no preference of one over the other. He would inform the PA Dep't of this as there had been some misunderstanding that NESP was to be used first because it was in a non PA status. Until reviewed by the P&T the status for both products would remain as is. Providers can use whichever product they prefer as both are covered.

After speaking with Leslie, the following things were determined: 1) Aranesp is currently NOT COVERED by TX Medicaid because of its hospital indicator status through First Data Bank 2) Procrit continues to be covered for all of its indications without a PA 3) The Drug Vendor Program has done their own cost analysis and knows that Aranesp is more costly than Procrit 4) Amgen has AGGRESSIVELY pushed coverage for Aranesp and it has not gone over well with the individuals at TX Medicaid. (Relationships remain very good with J&J and OBI.) 5) In the event that Aranesp does receive coverage in the future (Leslie does not see that happening unless it comes from above within the program), she cannot utilize the cost data due to the structure of the program which does not allow for PAs or preferred drug lists. It would simply be covered similarly to Procrit.

At this time Jerry Johnson (SGA) does not believe that it would be in PROCRIT's best interest to make a call on Illinois Public Aid. The state is in the process of seeking "supplemental rebates" from manufactures and has retained Provider Synergies as their agent to coordinate the rebate process. The way the system works is that the states identifies high cost drug classes and asks Provider Synergies to contact the companies for both clinical and cost information. Provider Synergies then makes a decision based on both criteria. That decision comes back to Public Aid and they send it to the Drug and Therapeutics Committee (the Illinois State Medical Society holds that contract) for review. The committee makes a recommendation back to Public Aid where the final decision is made. My concern is that by going in and bringing attention to this class, we may get reviewed sooner than we would have without bringing attention to the class. Also, Tuesday Williams and I have already worked with Public Aid's pharmacy advisior (Dr. Bob Buckman) on the issue of PROCRIT and Aranesp. Due to Tuesday's excellent work with I

Follow Up

1.) Target top 5 most influential P&T Committee members to deliver clinical and cost calculator info. Also target Chairman of P&T Committee. (Work with DM's and Product Specialists that have members in their territories).
2.) Find out when the category review is on the agenda. 3.) Find out about MedImpact's position on status of Procrit and NESP 4.) Secure speaker for P&T Committee meeting when this category is reviewed.

Richard Ponder will continue to monitor Aranesp coverage. In the event that TX Medicaid ends up putting Aranesp on its formulary, we will reapproach the program. Leslie was very open to seeing the cost calculator at that time.

- Call on Provider Synergies

Update of Medicare and Medicaid Clinical/Cost Calculator Presentations

Strategy: To present a clinical and cost comparison of EPO and NESP to the federal and state payers in order to demonstrate clinical and financial superiority for EPO.

Goal: Medicare payers to initiate LCA, with EPO as the basis for the price being paid as well as to maintain a level field of play in Medicaid.

Tactics: The Regional Clinical Affairs Managers and the Reimbursement Managers call on the Medicare Medical Directors in every state for Medicare and the top 10 states in Medicaid, plus 2 states that EPO has a competitive disadvantage (70% of PROCRIT business).

Results: As of May 3, 2002

- Medicare – Carrier Medicare Directors that represent 23 states have received the comparison presentation. CMDs for 12 more states are scheduled in May.
  - This represents:
    - 70% of all states
    - 2 of 3 Cancer Work Group members (CA-S, MS)
    - 3 of 5 ESRD Work Group members (MS, AL, HI)
    - 9 of 17 New Technologies – Medicine Work Group members (TN, MS, SC,MO, CA-S, IA, AR, MN, PA)

- Medicaid – There are appointments in 6 states, 2 other states are not going to be called on due to current issues and 3 states are waiting for an appointment. Kentucky has already been called on and the message was well received.

	States Called On as of May 3, 2002	**Appointments in May**
Medicare	Arkansas, Alabama, California – N, Georgia, Idaho, Illinois, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Nebraska, North Dakota, Ohio, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Utah, West Virginia, Wisconsin	Alaska, Arizona, California – S, Hawaii, Indiana, Kentucky, Montana, New Mexico, New York, North Carolina, Oklahoma, Virginia, Washington,
Medicaid	Kentucky	California, Florida, Iowa, Louisiana, Maryland, New Jersey, New York, North Carolina, Pennsylvania

States that have refused the Medicare presentations – Colorado, Connecticut, Delaware, Florida, Maine, Massachusetts, Maryland, Michigan, Nevada, New Hampshire, New Jersey, Rhode Island, Texas, Vermont, Wyoming. *

Common Responses from Medicare Medical Directors:
- "If the dosing of NESP is at the levels in these comparisons, we will consider an LCA"
- "In 6 months I will evaluate the dosing levels of the two drugs to see if any action should be taken"
- "This is a CMS issue, not a local issue"
- "There is not enough data to make any comparisons in the cancer market"
- "We need studies that compare the two drugs in the same cancer and being treated by the same chemotherapy regimen"
- "Doing an LCA is a lot of work, when we know we will not be supported by CMS"

Follow-up Activities for Medicare:
- Continue to request CMD appointments with carriers that denied the appointment.
  - Utilize CMDs that have already seen the presentation.
  - Provide a packet to the CMDs that have refused the appointment.
  - Utilize policy managers to facilitate appointment with CMD.
- Continue to pursue the Medicare Regional offices to see the Medical Director for the presentation.
  - Utilize contacts within the Regional offices to secure appointments.
  - Utilize the CMDs in the region to facilitate a meeting.
- Follow-up with the CMDs that said they would analyze the dosing regimens of NESP in the time period that they suggested.
  - Utilize field intelligence on dosing regimens of local providers for NESP

Follow-up Activities for Medicaid:
- Partner with the SGA Directors to monitor the status of EPO and NESP concerning Prior Authorization of the two drugs, as well as any other requirements.

* Waiting on approval from legal for cover letter for packet

State	Carrier	CMD Name
AL	BC/BS of AL	Dr Fred Robertson
AZ	Noridian	Dr. Mangold
CT	FCSO	Frank Delli Carpini, MD
GA	BC/BS of AL	Dr. Maner
HI	Noridian	Dr. Fong
IA	Noridian	Dr. Hertko
ID	Cigna	Dr. Donald Norris
IL	WPS	Dr. Boren
IL, MI, MN, OH,WI,IN	Region 5	Dr. Haywood / Dr. Boren
WI	WPS	Dr. Bussan
IN/KY	AdminaStar Federal	Dr. C. Cunningham
LA	BC/BS AR	Dr Lynn Hickman

MA, ME, NH, VT	NHIC	Dr. Charlotte Yeh
MD,DC,DE	HGSA	Dr. Laurence Clark
MI	WPS	Dr. Rosenberg
MN	WPS	Dr. Brook
MO-E	BC/BS AR	Dr. James Schell
MS	BC/BS of AL	Dr. James Strong
MT		Dr. Fred Olson
OR	Noridian	Dr. George Waldmann
N. CA	NHIC	Dr. Rogan
NM	BC/BS of AR	Dr. Mayo Gilson
NY & NJ	Empire	Dr. Rainford

NY Queens	GHI	Dr. Presto
NY Upstate	Western	Dr. Cox
OH/WV	Nationwide	Dr. R. Kamps
OK	BC/BS of AR	Dr. Mayo Gilson
PA	HGSA	Dr. Andrew Bloshichak
RI	BC/BS of RI	Dr. Parker Staples
S. CA	NHIC	Dr. Lurvey
SC	Palmetto GBA	Dr. D. Sheridan

TN	Cigna	Dr. E. Winter
TX	Trailblazers	Dr. Charles Haley
VA	Trailblazers	Dr. David Perez
CO, WY	Noridian	Dr. Szycz(stish)
WA	Noridian	Dr. Dick Whitten
FL	BC/BS of FL	Dr. S. Sewell
NC	Cigna	Dr. B. Honecutt
AR	AR BC/BS	Dr Sidney Hayes
KS, NE, MO	BCBS of KS	Dr. Pat Price

Appointment Date	Appointment Time
4/4/2002	1:30 CST
16-May Requested meeting by phone on 3/25 and declined meeting.	10:00 AM N/A
4/2/2002	3:00 EST
13-May-02 26-Apr-02	9:00 AM 10:00 AM
April 29th	2:00pm in Boise, ID
4-Apr-02	11AM
4-Apr-02	11:00 AM
29-Apr-02	
15-May-02	1:00-2:00 PM
2-Apr-02	11:00 AM

Meeting declined

Executive summary and Dr. Stone information sent via e-mail with a request for a meeting

Waiting to confirm

17-Apr-02	2:00 PM
4/22/2002	1:00 PM CST
4/4/2002	1:30 PM CST
15-May-02	3PM
April 30th	8:00am
April 25th	9:00 AM
5/10/2002	8:00 AM CST

1) CMD requested information - Appointment pending 2) Sent follow-up letter including Dr. Stone information 3) Will follow-up this week with phone call. 4) Dr. Rainford currently reviewing information.

1) Called to schedule appointment - Waiting for response 2) Additional call to Estalida in pricing - She requested information. Sent follow-up letter to Estalida and CMD including Dr. Stone information 3) Will follow-up weekly with phone calls	
16-May-02	1:30 PM Eastern
25-May-02	1:00 PM Eastern
5/10/2002	8:00 AM CST
4/11/2002	11:00 am Eastern
Meeting declined	
15-May-02	1:00 PM
4/18/2002	2:00 PM EST

1-May-02	10:00 AM

requested meeting; sent information regarding Dr. Stone and Dr. Price; waiting for reply

7-Apr-02	3:00 PM

7-May-02	1:00 PM
May 20, 2002 -Mtg. with T.Ewers-Ed.Rep April 17th	11:00 AM

Requested information to review prior to scheduling mtg.

	5/17/2002 10:00
4/25/2002	11:00am

Results

Presented information to Dr. Robertson (Part B), Dr. McKinney (Part A) and policy analysts. All were surprised by the cost differential. He will not issue a LCA policy at this time. He listed the following reasons:

- Needs to see how MD will use NESP/ Needs Claims date to make realistic comparison
- Indicated that the LCA Lupron / Zolodex policy was based on retrospective claims analysis
- Questioned whether a LCA would need to be put out for comment
- If LCA were applied, would the 200-1 be defendable

Positive comments:

- He would have no difficulty applying LCA IF NESP is consistently used in the dosage amounts that we compared
- Wanted to see Utah policy

Just like in the Lupron/Zolodex scenario, Dr. Delli Carpini said he cannot implement a LCA provision, because that is direction that comes from CMS-central office.

Met with CMD Dr. Maner. He agreed that NESP did not seem to provide any clinical advantages. He would issue an LCA only after reviewing usage. He has seen very limited use. He is retiring on 4/15/02

Dr. Hertco requested that all other Noridian CMD's view this material. He will mention at next conference call. He feels that they are likely to evaluate LCA because they have done this for lupron/zoladex.

Dr. Norris felt that it was up to CMS to decide LCA. We informed him of the 4/25/02 meeting with CMS where they pushed back and said that it was a local issue. He will take this information to the Region X office (in Seattle) because they are vocal and helpful. He will also mention that Dr Houck and others should see this presentation.

Met with Dr. Boren (CMD)and Dr. Haywood (Reg. Med Dir) and regional pricing analyst. Dr. Boren felt that he would not pursue LCA at this time. They have not seen claims for the use of NESP. Dr. Haywood stated that he would investigate LCA if a CMD asked him to. Agreed to look at claims data retrospectively.

Met with Dr. Haywood at Dr. Borens office. Dr. Haywood felt that he did not need CMS to investigate a LCA policy. He was more likely to initiate the analysis for an LCA than Dr. Boren. Dr. Haywood stated that he would consider LCA if Asked by a CMD .

Dr.Bussan (WPS-WI) wants Dr. Brooks (MN) to take the lead on the LCA issue. MN is currently the only WPS state with LCA for Lupron/zoladex. Dr. Bussan is also looking for CMS support on LCA.

Dr Hickman states that if NESP and PROCRIT (based on what the Provider request) are considered for treatment of anemia in LA, he would initiate analysis of claims to consider LCA. He also states that All AR BC/BS CMD's should see this presentation. He states it is very informative, and he would not consider paying for the convenience of NESP dosing.

Dr. Brooks found information compelling. Dr. Brooks also stated that a retrospective analysis of the data would be required. She was not aware of the amount of EPO that her providers use. Agreed to look at claims data retrospectively for NESP.

Dr Schell appreciated the information. He states that this appears to be a LCA issue. Dr Schell states LCA would be difficult to initiate and enforce. He also states that it would be after claim review to determine what dose of NESP the Provider is utilizing. He thought it would be @ 6 months of claims on NESP to see what was the clinical usage.
Met with Dr Strong and Policy analyst to discuss LCA. Both were amazed with the difference in cost of treatment particularly to the patient in co-pays. Dr Strong states that he is not aware of abundant usage of NESP (CRF or chemo-induced). He also states that LCA would be reviewed (as Lupron and Zoladex case). Dr Strong states that he must talk with AL and GA to be consistent. Strong would like the calculations in print if available. Will not implement LCA at this time.

Dr. Waldmann felt that our clinicals were comparing apples to oranges. Roxanne Meyer did an excellent job explaining that the comparisions done were all that is available- and that yes it is confusing as to what dosing NESP will really need. Dr. Waldmann requested that this be taken to Dr. Whitten (CMD WA/AK)- as he is "in charge" of the EPO policy. He also felt that there needs to be support from CMS- Regional and Central.

Dr. Rogan stated that he would look at 6 months data as to what Medicare pays per beneficiary for both Procrit and NESP for the CKD and chemo induced anemia prior to determining if a LCA should be instituted. Commented that he would like to see more comparative data in chronic diseases; commented also that he was not sure as to whether there could be any equivalence of dosages between Procrit and NESP at this time. Impressed with calculator and cost differential, however, more concerned about incentive for MDs to use the drug with more profitability.

Met with Dr. Kamps with M. Reese and E. Muser also attended. Presented clinical and LCA info. Dr. Kamps was very interested and wanted copy of cost analysis and clinical studies info. He stated that he was morally obligated to make the best decision financially for Nationwide. He had not reviewed any NESP claims -- all those claims would have to be handled on a case by case basis.

Met with Dr. Bloshichak (CMD) and Gene Risoldi (Medical Affairs Analyst). Mark Reese and Janet Lopez were also in attendance. Dr. Bloshichak and Gene were shocked at the cost differential between PROCRIT and NESP. Prior to our meeting, Dr. Bloshichak was unsure of other options concerning NESP payments. After our presentation, he asked how we could help him obtain the necessary information to assist with his LCA efforts. Dr. Bloshichak stated he is also going to share this information with CAC members and other Medicare contacts.

M. Reese, S. Willett and Sue Watson met with Dr Sheridan, and Policy analysts, D. Boyd, RN and J. Kozdras, RN. Dr. Sheridan was very receptive to the information and the cost analysis. His position on the issue is as follows:
- Is aware of the "LCA" discussions among carriers on the issue
- Interested in dose creep
- Agrees that the NESP / EPO could fit the criteria
- Would consider an LCA decision based on retrospective analysis

He requested a copy of the cost calculator and slides clinical data. (See follow-up)
Policy analysis confirmed the request to use NESP in oncology, currently they are not paying in oncology yet: expect to be with compendia listing.
Currently only CKD use of NESP was being reimbursed. Policy nurses confirmed that the cost calculator doses in CKD reflected "real world" doses that they were seeing.

Mark Reese and Ekik Muser and Paul Harrismet with Dr E. Winter and S. Walker (policy analyst) May 1, 2002 in Nashville. Results- Winter and Walker appreciated the presentation and the cost associated with each drug. Will pay for NESP for CKD and cmpendia listing. If calculation can be reproduced by him after NESP dosing has been determined, Winter states that this could be a LCA situation. However, LCA will be very difficult to initiate and enforce. Needs CMS support/direction. Will conference with Norris and Honeycutt.

Met with Debbie Lawson, advisor to Dr. Perez. I shared the Locatelli article and the 200u to 1 mcg conversion. She agreed that NESP does not provide any clinical advantages and the cost to the payor and the patient is substantial. She will be sharing this information to Dr. Perez on Friday April 10th and get his thoughts on this information and how the LCA might apply. I will follow-up with Debbie the following week to get Dr. Perez's thoughts.

4/17 Was able to see Dr. Whitten- as was visiting T.Ewers. T.Ewers believes that we have a good point, and is researching lupron/zolodex to assist with Dr. Whitten. Dr. Whitten agreed to meet, but only when we can leave material behind so that he can 'digest' information.

Dr Hayes very cost conscious with Procrit and NESP. Appreciated the cost calculator. Hayes referenced the AHRQ (Tech) report and questioned 30k vs 40k. Will not include NESP into Procrit policy unless Amgen can define equlivant dosing. Hayes has serious reservations because of the conversion confusion. Hayes states that this could explain the confusion (lack of direction) from CMS. Hayes also requested the Dr Stone (Utah) statement concerning NESP.
DR. Price will not implement LCA - he is awaiting direction from CMS. However, he has implemented a "PROCRIT First" policy. The provider must show that the patient was first given PROCRIT and failed. If subsequently given NESP - the provider must show medical necessity.

Other

Dr. Delli Carpini (CMD) re-emphasized that interaction between a CMD and a pharmaceutical company is a conflict of interest, therefore he cannot have any interaction with any drug companies. All discussions, must occur through the CAC members.

This CMD is the only board certified hematologist

1. WPS does not have LCA in MI, IL, WI at this time for Lupron. 2. Dr. Boren is requesting direction from CMS to prevent a lawsuit similar to Dr. Sheridan (SC)

1. WPS does not have LCA for Lupron at this time. 2. Dr. Haywood is relatively new at his position.

Felt that CMS does not support the carrier if legal issues arise from LCA.

Dr Hickman would really appreciate some of the calculations in a written form. He was very impressed by the difference in the treatment cost.

Customer service called on behalf of policy analyst and said that it is not NHIC's practice to have meetings with pharmaceutical companies.

Dr. Brooks stated that WPS first needed to get on the same page as far as the Lupron LCA policy was concerned before anything could be considered. MN is the only state in WPS that has a LCA for Lupron. Dr. Brooks stated that this LCA could not be considered until the Lupron issue was settled.

rescheduled meeting so that P. Harris could attend in place of P. Zak

He also stated that Amgen had been to see him the day before, but they were presenting a new white blood cell product they are promoting. At the end of the call he said they mentioned that NESP was in the USPDI for oncology.

rescheduled meeting so that P. Harris could attend in place of P. Zak

Dr. Staples said he said he did not have to wait for direction from CMS, but it could get contentious trying to prove that two drugs are identical. Dr. Staples said that Lupron/Zolodex were considered clinically comparable and that implementing a provision similar to his Lupron/Zolodex policy would be premature. I mentioned that many CMDs are having the discussion, but Dr. Staples said that they are bolder than he was.

Meeting after CAC meeting
Suggestions made to see Peter Houck, MD Region X Medical Director. B. Cruz has been trying to get to him, T. Ewers will try to help too.

E. Muser had Hayes to sign Medical information form for additional info. I provided the Dr Stone writing.

CMD Visit Follow up

1. Will provide the Utah policy. 2.Follow-up in July to get his thoughts on utilization. Attempted to contact regional office via Dr. Gary Noble. Will continue to pursue regional office through Gary Noble.

1. Coordinating with Scott Willett to get packet of information to CMD through FCSO-FL's CMD. 2. Searching for provider that will discuss with CMD, difficult since nature of discussion takes money out of providers pocket.

Follow-up with the M. Simon and new CMD in May to present the information on clinical as well as financial.

Will inform Dr. Hertco of other CMDs appointments so that he can follow up with them on conference call.

Sent thank you to CMD, and a reminder that we are available to meet with anyone necessary at the Region X office. Provided the LCA statement from Utah, and Dr. Price (KS) letter.

1.Will follow up in 4 months to discuss retrospective analysis of claims data

1. Will follow up with Dr. Haywood with printed calculator pages. 2. Will follow up to see if he has any questions concerning clinical data that he requested. 3. Will ask about retrospective analysis of dosing data for NESP
Will f/up with Dr. Bussan in 4 months to monitor NESP progress.

1. Will provide Dr. Hickman pages from the cost calculator. 2. Will follow up with Dr. Hickman to discuss retrospective analysis of NESP claims.

1. Will send packet of information. 2. Working with Joan Bost and Mark Reese to provide this information through Dr. Rogan (CMD - NHIC California). Meeting with Dr. Rogan is April 26.

A second E-mail was sent to Dr. Clark on April 19th requesting a meeting. This was in addition to several telephone calls made requesting a meeting as well. Will continue to follow-up the week of April 22nd.
Waiting for meeting with Dr. Brooks in WI to confirm appointment
1. Follow up with Dr. Brooks concerning clinical data that was requested. 2. Follow up in 4 months to initiate retrospective analysis of NESP claims.

1. Provide cost calculator pages to Dr. Schell. 2. Follow up in 4 months to investigate his feelings on a retrospective analysis of the NESP claims.

1. Will provide Dr. Strong with the pages from the cost calculator. 2. Will continue to discuss the utilization NESP and the doses being used, in order to retrospectively analyze the data.

Sent thank you, and informed of Dr. Hertco's request for all Noridian CMD's to view this information- and that Dr. Hertco will be addressing this on a conference call.

F/up thank you, verifying taking data for 6 months to find out what NHIC is paying per benificiary. Also asking if any materials needed from OBP.

1. Sent follow-up letter including Dr. Stone information 2. Will follow-up weekly with phone calls to secure an appointment. 3. After meeting with Dr. Cox (CMD upstate NY) I will ask Dr. Cox to assist in getting an appointment with Dr. Rainford.

1. Additional call to Estalida in pricing - She requested information. Sent follow-up letter to Estalida and CMD including Dr. Stone information 2. Will follow-up weekly with phone calls to secure appointment.

1. Will follow up with pages from calculator as soon as I receive new calculator. 2. Will follow up in 4 months to discuss retrospective analysis of claims data.

1. Provided clinical information from the CA department for Dr. Bloshichak. 2. Will also provide Dr. Bloshichak pages from the cost calculator.

Declined meeting and packet of information. Will discuss information with CAC member.

1. Will provide the pages from the cost calculator. 2. Following up with Clinical Affairs, Dr. Sheridan wanted the slides from Sue Watson presentations.

Will send Dr Winter and Ms Walker the print-out of calculations and Winter asked for overview of our presentation in bullet points.

tried to follow up with Drug Pricing Analyst three times but she has left the company; spoke with Policy Analyst who refered me to website to submit request; continue to send e-mails and voicemails directly to CMD
Debbie Lawson received an e-mail back from Dr. Perez on April 18th. He is interested in additional information. As soon as the LCA packet is ready, I will send it out to Debbie. In the meantime, Debbie told Dr. Perez, the Amgen representatives are out of control with how they are promoting ARANESP. They are pushy, aggressive and providing mis-information to the provider community. She told him she has NEVER seen anything like it in the 20 years she has been in the healthcare industry.

Coordinating with Eric to get packet of information to CMD and CT's CMD.

Will continue to keep Dr. Price aware of the activities the other CMD are doing around LCA issue.